Should radiologists and pathologists talk to patients?

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TO THE EDITOR: The practice of radiology and pathology has changed dramatically in the past two decades. Increased use of multidisciplinary assessments and interventional techniques has meant greater exposure of patients to radiologists and pathologists. When patients undergo investigations, they are invariably anxious, usually expect the worst, and want the result as soon as possible. Therefore, there is pressure to provide an immediate answer to the problem at hand. In most instances, it would be possible to offer a diagnosis. However, many radiologists and pathologists are reluctant to discuss investigations with patients in detail.[1]

During interventional procedures, radiologists and pathologists see patients only briefly; they often don't know all the facts about them, and are not ultimately responsible for their clinical management.[1] As the patient is only temporarily in the care of the radiologist or the pathologist, it is not appropriate to discuss complex issues or offer opinions and advice. Such advice may put the patient's doctor in an awkward position, forcing the referring practitioner to follow a course of action which may not be in the best interests of the patient.

At a patient's insistence, radiologists and pathologists can sometimes indicate to someone who has a clearly benign condition that the problem under investigation is unlikely to be serious.[2-4] This may be the case with screening mammography, as, in most cases, the results are either normal or indicate a non-malignant condition. However, in diagnostic radiology and pathology, such an opinion is usually based on a preliminary impression, which may change when all the facts are considered.

The cost of providing on-the-spot written reports to the patient has to be factored into the equation. It has been estimated that the additional cost of immediate reporting of results of screening mammography is about US$28.22. When additional equipment and space were not required, the cost would increase by US$4.38. Although most patients in the study preferred immediate reporting, they were unwilling to pay the additional fees.[5] With respect to pathology, a formal fine-needle aspiration result can be delivered within an hour, but, for the reasons outlined above, this would not be advisable. Further, the pathologist's contract is with the referring doctor and the report is written in scientific language, which may not be easily understood by the patient, leading to unnecessary anxiety.

Giving bad news to a patient is not an easy task even for trained professionals. It is even harder for radiologists and pathologists who are not generally equipped to provide counselling and support, and who may not be indemnified by their insurers to carry out such tasks. Further, neither radiology departments nor pathology laboratories are suitable settings for giving bad news,[1] as very few support avenues are usually available to patients there.

Predicting the impact that bad news will have on a patient is extremely difficult, and radiologists and pathologists should, for compassionate and for medicolegal reasons, refrain from providing immediate answers to patients.

1. Valley SR, Manton Mills JO. Should radiologists talk to patients? *BMJ* 1990; 300: 305-306.
2. Bury RF. Should radiologists talk to patients? *BMJ* 1990; 300: 610.
3. Charig M. Should radiologists talk to patients? *BMJ* 1990; 300: 610.
4. Watt PCH, Caughley L, Varma M. Should pathologists talk to patients? *BMJ* 1990; 300: 1079.
5. Raza S, Rosen MP, Chorney K, et al. Patient expectation and cost of immediate reporting of screening mammography: talk isn't cheap. *Am J Roentgenol* 2001; 177: 579-583. ❑

Correspondents

Letters must be no longer than 400 words and must include a word count. All letters are subject to editing. Proofs will not normally be supplied. There should be no more than 4 authors per letter. Each author should provide current qualifications and position. Contact telephone and facsimile numbers should be supplied. Letters from a single author may be submitted by email (editorial@ampco.com.au), but must include full details of postal address and telephone number. There should be no more than 5 references. The reference list should not include anything that has not been published or accepted for publication. Reference details must be complete, including: names and initials for up to 4 authors, or 3 authors, et al. if there are more than 4; places and dates for conferences and publishers, places and year of publication for their proceedings; publishers, places, year of publication and page numbers for monographs; volume numbers and page numbers for journal articles.

The demise of a planned randomised controlled trial in an urban Aboriginal medical service

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TO THE EDITOR: Jamrozik's editorial[1] about our report of a failed randomised controlled trial (RCT)[2] in an Aboriginal medical service helps to explain why researchers might be reluctant to submit articles describing unsuccessful trials, thus limiting potential for the scientific community to learn from such experiences. The main point of our article was to describe the manifest difficulties of implementing an RCT — the evidence "gold standard" — in this type of setting. Interestingly, Jamrozik largely attributes these difficulties to incompetence or naivety (or both) on the part of the researchers and funders, rather than to complexities inherent in the study design, the setting and the intervention.

A separately funded pilot study is, in principle, a good idea, but extremely difficult to get funding for in today's environment. Of course, we did conduct a pilot — that, in fact, was what we reported on — but it is unclear how this would have helped us better estimate absolute prevalences and effect sizes for intervention and control groups, as a substantial number of participants, *followed up for six months*, would have been needed to do this.

Nor is it clear how taking a population approach and distributing guidelines to all drinkers rather than offering personalised advice to hazardous drinkers would have helped — firstly, because we were specifically trialling the internationally validated brief intervention, and secondly, because the effect size of the alternative approach would have been so small that we would have needed very much *larger* numbers to test its effectiveness. We had no intention of "stumbling down something like this path".

Nor do we agree that the blood tests were "medicalising a social problem". They were intended not only to provide robust outcome measures (a mark of a good trial),

but also tangible evidence to clients of the health effects of alcohol, shown from previous research to be well received by Aboriginal people.[3,4] They were not a requirement for participation.

Further, that we should have got around the potentially off-putting business of seeking informed consent by bypassing this step almost defies comment. While trials of some therapeutic interventions can be undertaken blind with patient consent by using placebos, this does not mean that where blinding is not possible patient consent should be done away with in order to avoid a Hawthorne effect!

However, we do agree with Jamrozik on one point — nothing about this study or our report could reasonably "compound any negative perceptions about Aboriginal Medical Services and Aboriginal patients".[1]

1. Jamrozik K. Hard lessons from a randomised controlled trial [editorial]. *Med J Aust* 2002; 176: 248-249.
2. Sibthorpe BM, Bailie RS, Brady MA, et al. The demise of a planned randomised controlled trial in an urban Aboriginal medical service. *Med J Aust* 2002; 176: 273-276.
3. Hunter EH, Hall W, Spargo R. Distribution and correlates of alcohol consumption in a remote Aboriginal population. NDARC Monograph no. 12. Sydney, National Drug and Alcohol Research Centre, 1991.
4. Markey P. The prevalence of ischaemic and rheumatic heart disease and risk factors in Aboriginal and non-Aboriginal footballers [MPH thesis]. Adelaide: Department of Community Medicine, University of Adelaide, 1996. ❑

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TO THE EDITOR: I am responding to a recent editorial by Jamrozik[1] commenting on a study proposed by Sibthorpe and colleagues to assess a brief intervention for hazardous use of alcohol by Indigenous people in an urban setting.[2]

After two unsuccessful attempts to recruit participants, the study was discontinued and funds returned to the National Health and Medical Research Council (NHMRC) in 1998. Sibthorpe et al identified their difficulties as primarily the result of having overestimated the number of suitable participants, for a number of complex reasons.

Jamrozik's criticisms rest disproportionately with the NHMRC and are based on procedures and processes in effect in 1996 and 1997, yet they are informed by contemporary knowledge and wisdom. This seems somewhat anomalous.

In 2000, the NHMRC revised its system for assessing research applications. This involved several developments which would have had a direct impact on the assessment of this application had they been instituted in 1996. Some of these include:

- the introduction of panels comprising 11 experts in the domain of the application;
- the introduction of the Indigenous Health Research Panel (IHRP), which provides advice on cultural appropriateness, community consultation and methods in applications with an Indigenous component (most members are Indigenous people); and
- the opportunity for IHRP to make stipulations upon which funding is contingent.

Also of significance was the establishment of the Research Agenda Working Group (RAWG), which oversaw the formulation of intervention-based criteria. Colloquially known as the "Darwin criteria", these principles ensure that all Indigenous research design has:

- sufficient Indigenous community consultation and participation;
- transferability (of the methods to other settings); and
- sustainability (of resulting changes).

The NHMRC was disappointed that the study by Sibthorpe et al did not proceed and did not result in usable data to inform a significant problem. However, it is also important to recognise that unanticipated outcomes, which can often lead to other, very positive results, are an integral part of the learning process.

The NHMRC has supported Australian health and medical research since 1936. It has a strong commitment to ensuring the continuing evolution of its procedures and practices. The new systems implemented in 2000 were designed to ensure the continuing tradition of funding high quality, relevant and applicable research.

1. Jamrozik K. Hard lessons from a randomised controlled trial [editorial]. *Med J Aust* 2001; 176: 248-249.
2. Sibthorpe BM, Bailie RS, Brady MA, et al. The demise of a planned randomised controlled trial in an urban Aboriginal medical service. *Med J Aust* 2002; 176: 273-276. ❑

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TO THE EDITOR: The recent article by Sibthorpe et al[1] and the accompanying editorial[2] on the issue of the failure of an alcohol intervention trial in an Aboriginal Health Service deal with problems facing all primary care practitioners in the field of "alcohol misuse" and should not be seen as a peculiarly Aboriginal problem.

Firstly, despite what the academics may tell us, administering an Alcohol Use Disorders Identification Test (AUDIT) questionnaire in general practice as a screening measure meets with huge resistance, no matter where you practice. Denial of the disease-inducing potential of alcohol is certainly not peculiar to Aboriginal society.

Secondly, I find that the bulk of the medical profession reinforces this community denial by diagnosing conditions such as diabetes, hypertension, obesity, anxiety, depression and schizophrenia instead of seeing these problems as being a manifestation of alcoholism or other "alcohol misuse" until proven otherwise. Indeed, the denial is so extreme that they tend to avoid the term "alcoholism" altogether. Specialists are in even greater denial and are more often a hindrance than a help to general practitioners in this regard. As a consequence, community leaders and affected families are unable to develop effective strategies for dealing with their problems. What they get instead is increasing healthcare costs, hospital bed shortages, increasing domestic violence, more "drug problems" and more prisons.

So "GP reluctance or inability to follow through…"[2] is not surprising. Indeed, denial of alcohol is so strong in the medical profession that it is harder, in my experience, to get doctors and even medical students (let along healthcare workers) to attend open meetings of Alcholics Anonymous and Al-Anon than it is to persuade affected people to do so.

Thirdly, general practice throughout Australia has been organised for episodic, fast-throughput care. People have become so accustomed to this that they see any attempt at a comprehensive preventive approach to illness as odd, out of place, time-consuming and even intrusive, especially so where alcohol and family histories are concerned. That Aboriginal people are no different from the rest of us in this regard should cause no surprise.

1. Sibthorpe BM, Bailie RS, Brady MA, et al. The demise of a planned randomised controlled trial in an urban Aboriginal medical service. *Med J Aust* 2002; 176: 273-276.
2. Jamrozik K. Hard lessons from a randomised controlled trial [editorial]. *Med J Aust* 2002; 176: 248-249. ❑

EBM in action

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TO THE EDITOR: I read with interest the recent correspondence in the Journal from Del Mar and Glasziou.[1] Their appeal to one of their critics was to "abandon throwing bricks from the sidelines and join us in trying to help clinicians assess research evidence in [a] timely fashion". More recently, their defence in relying on generalists, rather than experts, to assess the evidence was, somewhat curiously, that "a